National HIV/AIDS Support Project (NHASP)

Gender Planning Framework

Milestone 36

December 2002

Managed by
ACIL
International Development Consultants and Project Managers

In association with
MBC

Funded by the Australian Government
AusAID

ABBREVIATIONS AND ACRONYMS

AusAID	Australian Agency for International Development
CBO	Community Based Organisation
CHW	Community Health Worker
CSW	Commercial Sex Worker
DoE	Department of Education
IAC	Information, Advocacy and Communication
GOPNG	Government of PNG
HIV	Human Immunodeficiency Virus
HRC	HIV Response Coordinator
IMR	Institute of Medical Research
K	Kina
MLA	Medical Laboratory Assistant
MLT	Medical Laboratory Technician
MSM	Men who have Sex with Men
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDOH	National Department of Health
NZODA	New Zealand Official Development Assistance
NGO	Non Government Organisation
NRL	National HIV Reference Laboratory
OIC	Officer-in-Charge
PAC	Provincial AIDS Committee
PDD	Project Design Document
PLWA	People Living With HIV/AIDS
PMGH	Port Moresby General Hospital
STI	Sexually Transmitted Infection
TOT	Training of Trainers
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
UPNG	University of Papua New Guinea
YWCA	Young Women's Christian Association

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Annexes

"The key to overcoming the HIV/AIDS epidemic is through transforming relations between women and men, so that women will be able to take greater control of their lives".

Kofi Annan, Secretary General of the United Nations

This report constitutes Milestone 36 of the PNG National HIV/AIDS Support Project (NHASP). The following table identifies milestone contractual requirements:

MS no	SOS ref	Description	Means of Verification
36	23.6	Gender Planning Framework	Final Gender Planning Framework approved by AusAID in accordance with clause 23.6 of schedule 1 of scope of services

The Gender Adviser was required to undertake an analysis that informs a Gender Planning Framework and suggest strategies to support the equitable and active participation of men and women in project management, planning and implementation.

In particular, the framework was to identify strategies to:

- incorporate a gender perspective into project activities;
- promote women's effective participation and leadership in decision making at relevant levels of project implementation;
- improve women's access to, and participation in, HIV/AIDS education and training activities;
- minimise the risk of gender discrimination across the six project components; and,
- monitor the NHASP gender planning framework in line with overall project monitoring and evaluation.

1. Introduction

In this report, a broad definition of gender has been applied in line with the UNAIDS definition as follows: "What it means to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships".

A gender framework for HIV/AIDS refers to a strategy of actions, planned and implemented, from the perspectives and needs of men and women that address the imbalance in power in their relationship, benefit them equally and contribute holistically to their full potential and well being.

An understanding of gender should be an integral part of every HIV/AIDS project and incorporated into all aspects of planning, strategies, programs and policy. Gender is a technical strategy that should be measured and integrated into training and implementation; with strategies developed to address the specific needs of different

populations, settings and situations. Resources, both human and financial, should be allocated to ensure gender strategies are addressed adequately, as they are for other technical approaches. Strategies should be continually re-appraised to ensure that they recognise and address identified gender needs.

The key issue in the implementation of the gender framework will be the sensitisation of stakeholders, including project advisers, to ensure that an understanding of gender issues is incorporated into the project's operational structures.

This report was developed in consultation with project advisers, project partners and through focus group discussions in three regions [Momase, New Guinea Islands, Southern]. Topics covered in focus group discussions included level of participation in the PNG National HIV/AIDS Support Project, access to and control of project resources, awareness regarding gender issues, empowerment, practical and strategic gender needs.

The report provides a brief overview of gender in the context of HIV/AIDS risk and gender issues in PNG, and includes a framework for incorporating a gender perspective into project activities, to increase women's participation in project activities and minimise the risk of gender discrimination.

2. Background

Globally, over 40 million people are living with HIV/AIDS. According to figures that emerged from the 2002 International AIDS Conference in Barcelona, of the 28 million people in sub-Saharan Africa living with AIDS between the ages of 15 to 49, 15 million are women (58 percent). Of the 8.6 million in the age group 15 to 24, 67 percent are young women and girls. Within the space of one generation, AIDS has become a leading cause of death among poor women throughout the world. Ninety seven percent of women with AIDS live in the developing world where women's precarious social status, a direct result of gender inequality and amplified poverty, magnifies biological predisposition. In most societies, women are denied equal access to economic resources, housing, health care, legal protection, education, and employment in the formal sector.

The UN Special Session on AIDS (June 2001) Declaration of Commitment acknowledges that women are overwhelmingly at risk of HIV/AIDS, and that *"Empowering women is essential for reducing vulnerability".* The Declaration contains a number of strong articles on the rights and protection of women. **(Annex 1)**

Everyone at risk of infection, whatever his or her gender, status or sexuality, has the right to protection from HIV. According to UNAIDS, understanding the influence of gender roles and relations on individuals' and communities' ability to protect themselves from HIV and effectively cope with the impact of AIDS is crucial for expanding the response. A gender-based response to understanding HIV/AIDS examines the ways in which gender influences:

- individual risk and vulnerability to HIV;
- the experience of living with HIV/AIDS;
- the impact of an individual's HIV-related illness and death within a family or community; and
- responses to the epidemic at the individual, community and national level.

An effective response to the epidemic must be built on an understanding of these influences.

Papua New Guinea is a country in the midst of rapid social and cultural transition as the traditional subsistence farming clan-based culture moves towards the urban nuclear family culture. For many women in PNG, the disintegration of familiar village support structures and social controls, and the loss of traditional roles, has led to disempowerment within the family and within society. Women are particularly disadvantaged in PNG, with high levels of violence against women, lower literacy rates and exclusion of women from the decision-making process. PNG is one of the few countries in the world where the life expectancy for women is lower than the life expectancy for men. The representation by women in all levels of government is only 4.3 percent.

The constitution and laws of PNG give women the same rights and opportunities as men. However, the status of women is still poor and many women are excluded from the benefits of development. In addition, the general community's tacit acceptance of domestic violence, rape and general violence against women reflects the low status of women in general. Men usually work outside the household, in formal or informal sectors. A key issue for women is gender-based violence, which constitutes a major constraint in overcoming the HIV/AIDS epidemic.

3. Gender Issues in PNG

Gender differences are quite evident in PNG where traditionally women have defined roles relating to most aspects of daily life. The status of women in PNG today has been determined by a range of interrelating factors including traditional roles and beliefs, religion, transition to technological culture, education, government policies, and economic status. For many women, the disintegration of familiar village support structures and social controls, and the loss of traditional roles, has led to disempowerment within the family and within society. Many women have been denied access to participation in community and political programs due to lack of education, low literacy and lack of confidence.

Traditionally, in many parts of PNG, the male was the head of the household and the decision maker. 'Big' men were leaders in the community and opinion makers. The colonial administration and early missionary groups perpetuated the role of the male as the decision maker and excluded many women from participating in development and educational activities.

Status for women has been related to the cultural importance of child bearing and the role as a mother and provider for the family. There have been significant advances for some women over the past 20 years, with increased participation in public affairs and politics, and the development of national policies and programs to address women's needs. However for the majority of women there is still a long way to go.

The perceived low status of women has contributed to the continuing community and political acceptance of violence against women, and domestic and sexual violence are major health risks for women in PNG. Even in matriarchal island society in PNG, women's power has been eroded through exclusion from decision-making in development programs and loss of control of land.

In many parts of PNG, the tradition of the husband paying a 'bride price' to the wife's family has continued. Originally the payment was made in pigs and shells but it is more common now for cash payments to be made. Payments put great pressure and

ongoing responsibility on the family and clan. In addition, in some provinces, the bride and the children are considered to be the property of the husband's family after payment of the bride price. Not only can this be used as an excuse for ill treatment or beating, it may prevent the wife from leaving her husband, as she is afraid of losing her children.

Polygamy is still practised in the highland provinces and many men still believe that having more than one wife is a symbol of wealth and power. Men, including married men, tend to have multiple partners, and 'serial' marriage is not uncommon. For many women the practice is distressing, and the most common murder by women in PNG is the killing of a second wife by the first wife.

At all levels and in all sectors, opinions from women are frequently challenged or overshadowed by men. Within the political system, only four women have been elected to National Parliament since PNG achieved independence in 1975. Section 102 of the Constitution allows for the appointment of up to three Members of Parliament, in a two-thirds majority decision. Section 101 provides for one woman to be elected in each PNG province, through an election within an election. Implementation of such strategies would increase the gender equity of PNG's parliamentary system. Securing the entry of a sufficient number of women into positions of political power would begin to challenge the masculinising of power.

4. Gender, Health Status and Access to Health Services

The low status and ill treatment of girls and women in PNG seriously disadvantages their prospects of living positively and enjoying family love and care. In most developed and developing countries, women live longer than men (for reasons not well understood, but many believe it to be due to biological pre-disposition). There are less than a handful of developing countries where women have a lower life expectancy than men, and PNG is one of these. This is a very powerful indicator of the poor status and health of women in PNG, along with the fact that females make up only 47.3% of the total PNG population.[1]

Most of PNG's diverse societies and cultures support male pre-eminence and dominance, which adversely affects women and children's health, limits their choices and opportunities to develop and fulfil their potential as equal citizens, and constrains their full and active participation in community development. Women and children from the remote rural communities are the most severely affected and disempowered, since they experience a highly restricted or even a total lack of access to basic education and health services. Heavy workloads, high levels of violence against women, heavy burdens of family responsibilities, poor servicing of women's reproductive health needs, along with a high personal security risk for women travelling, has a profound impact both on the health of women and children, and on women's sense of self-worth, self-esteem and rights. Poor literacy, the negative way women are commonly treated in marriage, and low levels of education all contribute to their health status.

[1] Life expectancy of women in PNG according to the 1990 National Census is 51.4 years, compared with 52.2 years for men. Other countries where women have a lower life expectancy than men include the poorest countries in South Asia, such as Bangladesh, Nepal and the Maldives. Sources include: United Nations 1995 The World's Women: Trends and Statistics: 65-67; and Katherine Lepani 1997 1. Figures for ESP are documented in Table 2 of Annex 8, which shows women having a slightly higher life expectancy than men (50 years for women compared with 49 years for men), which is again one of the smallest gaps between male and female life expectancy in the world, indicating low status of women.

Another important factor in PNG, particularly in rural areas, is the heavy and constant workload carried by women. When combined with poor nutritional status and food distribution practices, which favour men, heavy workload has a severe impact on the health of women and girl children. While poverty affects the health status of women, men and children, these and other factors make women more vulnerable to ill health.

Lack of confidence and self-esteem of women prevents them from accessing formal health services for both their own and their children's health. Heavy workloads and the burden of family responsibilities may also prevent women from seeking treatment for themselves or their children, or from seeking advice or information on antenatal care. Women face a higher security risk when they travel to health centres on their own, and the justified fear of violence in transit may prevent them from seeking treatment.

In some places, women need men's permission to go to health centres, and there is a tendency for men to give higher priority to women attending to childcare and subsistence responsibilities (fishing and gardening) rather than attending to their women's health needs. Women also tend to give priority to caring for their children and ensuring the family's food supply over their own health needs. There is a tendency for men to wait until women are very sick before giving permission to attend health centres.

Women need money to leave the village, to travel to health facilities and to stay away from home. This may be denied. Men's permission is also a critical factor in preventing women from seeking treatment for STIs, due to shame, and a refusal on the part of men to accept responsibility for spreading infections. However, men will generally seek treatment for themselves when they contract STIs, even if it is just advice from a friend.

Where women or children suffer from injuries due to violence perpetrated by their husbands/partners/fathers, men may also refuse to give permission for treatment, or may actively prevent women from getting treatment by the threat of further violence. Women may not try to access condoms or sexual health information because of lack of privacy, shame, lack of trust, lack of permission or agreement from partners/husbands, misinformation, religious beliefs which prohibit contraceptives, and in some cases fear of sexual assault by health workers. Both women and men may not have trust in the ability of health workers to provide quality health care, and guarantee confidentiality. Women may be deterred from attending health services staffed by men, due to shame, fear and lack of trust.

5. Gender, Violence and HIV/AIDS

Violence continues to be a major problem at all levels of society, with high rates of violent crime, ongoing tribal disputes in rural areas, and widespread domestic and sexual violence against women. Male violence is commonly used to control women throughout their lives. Women are particularly vulnerable, with violence, including sexual violence and rape, being socially sanctioned by many sections of the community. In the last two decades women's movements have consistently emphasised that the issue of violence against women is not a 'cultural' or 'private' affair.

High levels of violence also have a very severe impact on the health of women and both boy and girl children. Violence and the threat of violence impairs women's capacity to provide for themselves and their children, and prevents their participation in all forms of social and economic life including development programs. Violence

associated with forced sex (rape, gang rape and other forms of sexual abuse) results in early and unplanned pregnancies, sexually transmitted diseases including HIV/AIDS, and long-term psychological trauma.[2]

HIV/AIDS prevention and care efforts must take into account the impact of violence on the ability of women to negotiate safe sex practices with the partners.

6. Gender and HIV/AIDS Vulnerability and Risk

It is important to consider vulnerability and risk in the context of gender roles and relations, and this section expands on the discussion above, examining vulnerability and a number of risk factors for both males and females in PNG.

6.1. Women's vulnerability to the impact of HIV/AIDS

Physiological differences in the genital tract cause women to be at higher risk of acquiring HIV and STIs than men. Young women are at even greater risk than older women as the cervix is more easily eroded, and intercourse may cause trauma. Sexually transmitted infections are a significant cause of morbidity in PNG. The complications of curable STIs make up the second cause of healthy life lost in women of 15 to 45 years of age after maternal morbidity and mortality. Many STIs are asymptomatic and untreated among women, which significantly increases their risk of HIV transmission. The training in Syndromic Management of STIs aims to reduce the prevalence of STIs in the community through improved diagnosis and treatment.

It is essential that women have access to information on sexual health, personal risk and safe sex practices. In PNG there are social proscriptions on women seeking out information or having knowledge about sexual health issues and STIs, thus limiting their ability to protect themselves. In addition, low rates of functional literacy, particularly among women, Christian and fundamentalist religious influences, impact on women's ability to access information. Many women also lack knowledge and understanding of personal risk, particularly married women with one partner. PNG's 1996 Demographic and Health Survey[3] found that only 65 percent of women had knowledge of AIDS, and of these, only 19 percent identified condoms as a means of protection against HIV transmission, and 73 percent did not perceive themselves to be at personal risk of acquiring HIV/AIDS. Behaviour change programs need to address perceptions of risk and understanding of sexual health and safe sex among women.

International research indicates that women often do not use a condom for a variety of social, cultural and economic reasons, including lack of power and control in sexual relationships, fear of violence, lack of access to condoms, economic dependence, and a need to articulate intimacy. In PNG condoms are still widely associated with promiscuity and sex work. In addition, few women have the agency to negotiate safe sex practices with their partners. While a trial of the female condom in PNG indicated that women found it acceptable and that there was a demand for it[4],

[2] Decock A, Katz C and Agale, J. 1997 *Talking Health: The Voice of Teens.* Report on the Findings of the Teenage Focus Group Discussions on Population and Reproductive Health in PNG. Waigani. NDOH and PFPP

[3] National Statistics Office 1997, *PNG Demographic and Health Survey 1996, National Report,* NSO, Port Moresby.

[4] Jenkins C. 1995. *A Study of the Acceptability of the Female Condom in Urban Papua New Guinea.* Goroka: IMR

the focus of the project's social marketing and training to date has been on the male condom.

Young women in developing countries are not only subject to traditional social expectations. Through development, they are exposed to a new set of social, cultural and economic norms and, in seeking self-actualisation and excitement, may form sexual relationships based on the exchange of money and goods for sex. Research by De Cock and Agale[5] (1997) and Jenkins[6] (1997) identified the fascination for young women of the "dark glass car" man. Programs targeting young women through peer education and development of appropriate materials are essential.

As has been discussed above, PNG is one of the few countries in the world where the life expectancy of women is shorter than that of men. Many women suffer from chronic ill health associated with chronic infections, malnutrition, heavy workload, anaemia and high fertility rates, affecting the immune system and the course of HIV/AIDS. It is important that health workers are aware of the special needs of HIV-positive women.

Poverty, economic needs, and a lack of income-generating opportunities contribute to the increasing occurrence of commercial and transaction sex in PNG. Behavioural studies focused on vulnerable groups found that most female sex workers are under considerable economic pressure to meet the basic needs of themselves and their families. The studies all indicate that there are a range of situations in which sex is exchanged for money and basic needs such as food, clothes and transport. Sex workers are marginalised and often lack the skills to negotiate safe sex.[7] Intervention programs need to address income generation and strengthen capacity to negotiate and practice safe sex[8].

In PNG a number of beliefs and traditions may increase women's risk of transmission of HIV/AIDS. There is a wealth of information available on culture and sexuality in PNG and it is important that health education and behaviour change programs are informed by research.

Finally, women are perhaps most vulnerable when a diagnosis of HIV is made during pregnancy. They must bear the guilt of the risk for the child, the blame of spouse and family, the stigma and discrimination within the health care setting and the community, and the responsibility for making decisions regarding breast-feeding and family planning after the birth. Often counselling is inadequate or not even provided, and information can be complicated and difficult to understand. If antenatal testing of women for HIV is to be provided then it is essential that trained and competent health staff and counsellors are available.

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[5] De Cock and Agale, 1997.

[6] Jenkins C. *Youth in danger: AIDS and STDs among young people in Papua New Guinea.* UNFPA, Port Moresby, 1997

[7] Jenkins CL. *Sex as work in Papua New Guinea.* Abstract PD0481 in Abstract Book Volume 2 of the Tenth International Conference on AIDS, Yokohama, 7-12 Aug 1994:325.

Jenkins C. *The Transex project: sex and transport workers, police and security men in Papua New Guinea.* In: Jenkins C, ed. Female sex worker HIV prevention projects: Lessons learnt from Papua New Guinea, India and Bangladesh. Geneva: UNAIDS, 2000:19-56.

[8] The IMR Transex project conducted a targeted sex workers peer education intervention program, identified as a UNAIDS Best Practice Model. The program was to be transferred to NACS and funded through AusAID until the EU project commenced. Unfortunately funding was stopped after a few months due to outstanding acquittals of K26,000 (subsequently acquitted).

7. Men and HIV/AIDS

Worldwide, HIV infections and AIDS deaths in men outnumber those in women on every continent except sub-Saharan Africa. By the end of 1999, 10 million African men were living with HIV. Young men are particularly at risk compared with older men, and about one in four people with HIV is a young man under the age of 25.

In the section above, we have discussed women and the special risk factors for HIV transmission that apply to them. While the Terms of Reference for this gender planning framework have focused on women's participation and access to information, we need to also consider men in the analysis and framework for the following core reasons:

- men still exercise control at all levels of PNG society including sexual decision making, and it is important to involve them and gain their support;
- in PNG the transition of society and social and economic development factors have heightened men's vulnerability;
- we need to understand male beliefs and expectations to be able to influence their behaviour.

7.1. Men's vulnerability to HIV transmission

Cultural expectations and practices regarding relationships with women and use of condoms are among the factors that increase men's risk of infection. In general men tend to have more sexual partners than women: A 1995 study by WHO found that in all of the 18 countries surveyed, men had more sexual partners than women. In addition, in a number of countries including PNG, formal or informal polygamy is practiced. Rates of male condom use in most resource-poor countries are still low and condom use tends to be inconsistent. The reasons for this include embarrassment, lack of experience, difficulty in finding or paying for condoms, beliefs regarding the uncontrollability of male passion or the importance of semen, the desire for children, high rates of alcohol or drug-related sex and sexual violence and, finally, the belief that the sensation will be reduced if condoms are used. While there is little information available in PNG on the use of condoms, anecdotal evidence indicates that these factors apply in PNG. Further research is needed among men to explore attitudes and knowledge about condoms.

In PNG male-to-male sex is still illegal and there is little public acknowledgement of men who have sex with men (MSM). Traditionally, there were practices of men to men sexual initiation rites. In present times, there is a small urban "gay" sub-culture and a much larger population of men who are married and have children but also have discreet male-to-male sexual relationships from time to time. In addition, PNG has an increasing number of men and boys (including very young boys) who trade sex for money or food, particularly in urban centres. Within urban nightlife in Port Moresby there is male-to-male sex among young men as a form of sexual release. Finally, there are many anecdotal reports of sexual violence or coercion of young boys in the church, communities and schools in PNG. It is important that MSM, male sex workers, and sexual abuse of boys is acknowledged and discussed openly in PNG, and addressed in sexual health behaviour change training and programs.

Alcohol and substance abuse have been identified as factors increasing high-risk behaviour among men. In PNG alcohol and marihuana have become major social problems and are linked to high rates of accidents, violent crime (including sexual

violence), and increased risk of STIs and HIV. As with many cultures in transition, the loss of traditional roles, breakdown of social support mechanisms, disempowerment of poverty, imposition of western values, unemployment, social apartheid of development, and forced separation from families for employment are all factors which contribute to high rates of substance abuse. Integration of HIV/AIDS education into programs of Community Based Organisations (CBOs) working in areas of sexual violence and alcohol usage is an important strategy.

Mobile occupations such as truck driving, and migration for work, refugee, civil unrest, or economic reasons are often associated with increased vulnerability to HIV infection. In PNG urban migration for economic, educational, or employment reasons is very common, particularly for men. Mining, forestry and plantation estates employ a mainly male workforce, and few provide accommodation for wives and families. Men are separated from families for long periods, and there are high rates of alcohol usage, accidents, sex for money, and STIs. In Lae, the sex workers collect money for servicing truck drivers and sailors from the company paymasters. The IMR Transex Peer Education Program provided an excellent model to address the needs of mobile populations, and it is important that similar programs are re-commenced as soon as possible.

Settings that increase risk for men include prisons and the military. In PNG the rate of male imprisonment is high and conditions are generally desperate. Sex between men, including rape, is acknowledged, and condoms are not available for prisoners. In addition, prisoners usually have to share razors. The development of sectoral policies and programs for HIV/AIDS is already a priority for the project.

Finally, in PNG traditional practices such as scarification, and more recent practices such as insertion of sub-coetaneous objects into the penis to increase sexual gratification place men at increased risk of HIV infection.

Working with, and persuading men to change some of their attitudes and behaviours, has enormous potential to change the course of the HIV epidemic and improve the lives of their families and their partners.

8. NHASP Gender Strategy

> "One of the most striking features of the response to the HIV epidemic to date is how few of the policies and programs we have developed relate to women's life situations. The daily lives of women and the complex network of relationships and structures that shape them are well known to all women and well documented. Despite this, our theories, research agendas, policies and programs have not been grounded in and informed by these experiences".
>
> **Elizabeth Reid**

The strategic approach to ensuring gender sensitivity in project planning and implementation will be to ensure that all project advisers and project partners have the understanding and capacity to incorporate gender into project planning and implementation. The project will develop processes to ensure that program planning takes into account differences in gender roles, access to resources, and decision making that affects women's and men's ability to protect themselves. The project will form links with key women's organisations and involve women in policy and program planning at relevant levels.

8.1. Project Targets

- gender-sensitive working environment in-country which ensures that attitudes toward female staff are supportive and equal;
- project advisers and partners have the necessary training to enable them to incorporate gender into the planning and implementation of their programs;
- project planning and programs relating to sexual behaviour address social norms, sexual beliefs, gender violence, and gender power disparities in relation to HIV transmission and vulnerability to HIV/AIDS;
- participation of women and women's organisations in all levels of project planning and implementation;
- project workshops, training programs and meetings planned and structured to facilitate active participation of women and men.

9. Review of Project Progress in Addressing Gender Issues

- a flip chart is being developed to address risk factors for women and men, including risks associated with alcohol and other substances;
- the Needs Assessment and Institutional Analysis for Home-Based Care includes a comprehensive gender analysis which summarises gender issues and includes a description of gender, health status and access to health services , gender, violence and HIV/AIDS, and gender implications for care and support for HIV/AIDS;
- gender has been integrated into all training modules, materials and programs for counselling and home care. Training modules include "Development of gender roles and relations", "Safer Sex" and "Sexual development and sexuality";
- processes and criteria for appointment of the provincial counselling co-ordinator positions, while based on merit, have ensured that women have had equal opportunities in the recruitment process;
- the STI training modules address gender and attitudes of health staff;
- the health sector training program has aimed to raise awareness and knowledge of all health workers regarding STI diagnosis and management through district-level training, and has negotiated for the inclusion of sexual health training in the PNG Women's and Childen's Health Project training program.
- STI clinic services are encouraged to provide both male and female staff to ensure same gender service providers are available;
- female condoms have been procured and distributed to the peer education program.
- the PAC Administration Manual includes a section on Equal Opportunity Guidelines for Employment.

10. Component Strategies to Address Gender Issues

10.1. Component 1: Education, Information and Advocacy

Component Objective: To strengthen and develop the capacity of government agencies, NGOs, and the private sector nationwide to raise the level of awareness and understanding of HIV and STD transmission and prevention among the general population, with a particular focus on youth, and to promote appropriate behaviour change.

Globally, the first generation of HIV/AIDS programs were gender-neutral in their approach and health education messages ignored gender disparities and roles in sexual relationships, and simply urged the population to "stick to one partner", avoid casual sex, reduce the number of sexual partners or use condoms. It is essential that HIV/AIDS programs are trans-cultural and relevant to the community; acknowledge the impact of gender disparities, sexual violence, structural violence and poverty on women's autonomy and ability to practice safe sex; are based on social research; and involve communities in planning and implementation.

Key issues considered in developing gender strategies for this component include the following:

- behaviour change programs must be based on an understanding of the contextual social and cultural factors that shape the reality of sexual behaviours, gender roles and expectations;
- without access to information about sex and sexuality or a basic knowledge of reproductive anatomy and physiology, women can do very little to protect themselves;
- cultural norms and traditions shape the interpretation and acceptance of health promotion messages;
- gender roles and power relations vary among the different cultures in PNG;
- engaging men as responsible partners is important in HIV prevention and care;
- increasing poverty and economic pressure leads to more women (and men) providing sex in exchange for money or goods;
- the disparity in status between men and women frequently leaves women vulnerable in sexual relationships and unable to negotiate safe sexual practice;
- sexual violence is a major problem with rape, including group rape, being tacitly accepted by many sections of the community.
- women have lower rates of functional literacy than men.

10.2: Component 2: Counselling and Home Care

Component Objective: to strengthen and extend HIV/AIDS counselling services to ensure national coverage and establish home-based care as the chief means of delivering health care services to people and their families affected by HIV/AIDS.

Component 2 advisers have extensive experience in gender issues and have worked in promoting women's rights and raising awareness of gender at all levels in PNG from senior policy down to community level. Gender strategies have been incorporated into training, materials and policies for counselling and home care.

Key issues considered in developing gender strategies for this component include the following:

- caring is gendered work and leads to non-valuation (taken for granted) and devaluation (em samting bilong ol meri) of counselling and home care;
- women testing positive to HIV at antenatal clinics are vulnerable to stigmatisation, guilt, and blame by spouse and family, especially in-laws/tambu);
- HIV-positive mothers experience anxiety, guilt and hardship, and need support and counselling including appropriate advice on breastfeeding and contraception;
- an understanding of and competence in dealing with the realities of violence, lack of rights, and control in sexual relationships is essential for counsellors and carers.

10.3: Component 3: Policy, Legal and Ethical Issues

Component Objective: the development of relevant policy, codes of ethics and enabling legislation regarding HIV/AIDS and STD prevention and care is essential to support the national effort in response to the epidemic. The capacity of the NAC and other government and private sector agencies to assist and facilitate such policy and legislation will be strengthened through this component.

PNG is a signatory to the ***UNGASS Declaration of Commitment (2001)***. The Declaration includes two key articles relevant to Component 3 *[over page]*:

> ***Article 37***: By 2003, calls on development of multisectoral national strategies for combating HIV/AIDS that address gender and age based dimensions of the epidemic and have full participation of those in vulnerable groups and people most at risk particularly women and young people.
>
> ***Article 61***: By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering, and trafficking in women and girls.

Component 3, in supporting and advising on the development of policy, can contribute to achieving these goals.

Key issues considered in developing gender strategies for this component include the following:

- sectors need to have an understanding of gender, gender violence and legal rights in developing policy and programs for HIV/AIDS;

- sectors and policy makers need an understanding of the impact of poverty, lack of education, unemployment and social dislocation on women's lives and the subsequent risk of contracting HIV/AIDS.

10.4: Component 4: Monitoring, Surveillance and Evaluation

Component Objective: to strengthen the public health surveillance of HIV/AIDS and STIs and related behaviour change through improvements in case definitions, data collection, reporting, analysis and feedback mechanisms including sentinel surveillance systems.

Epidemiological studies provide invaluable information in monitoring the course of the HIV epidemic and the response. Sero-surveillance in PNG has focused on women attending the antenatal clinic in Port Moresby and on female sex workers in Port Moresby and Goroka. While this has provided significant information, it has led some to a misperception that women are responsible for the epidemic. It is important that the second-generation surveillance program expands to other sites and populations, including MSM, and that behavioural surveillance explores the social and cultural context of risk for women.

Key issues considered in developing gender strategies for this component include the following:

- surveys may target female populations such as those attending antenatal clinics (because accessible) and sex workers (high risk behaviour group;

- surveillance planning needs to consider the impact of being HIV-positive on women screened;

- surveillance should address the needs of all gender groups, including male sex workers and MSM;

- behavioural surveillance should address contextual social and cultural factors that shape sexual behaviour.

10.5: Component 5: Medical Services and Laboratory Strengthening

Component Objective: to improve the quality and delivery of STI and HIV/AIDS services through enhanced diagnosis, clinical management, and community care.

Gender inequality is a significant risk factor in both HIV and STI transmission not only because of biological differences between men and women but also because of the disparity between men and women in relation to access to economic resources, control over sexual and reproductive decisions, and access to medical care. The NHASP advisers working in the health sector have identified several strategies to address gender disparities in relation to access to clinical care and HIV/AIDS information.

Key issues considered in developing gender strategies for this component include the following:

- sexually transmitted infections are a significant cause of morbidity in PNG. The complications of curable STIs make up the second most common cause of loss of healthy life in women aged 15 to 45 after maternal morbidity and mortality. Many STIs are asymptomatic and untreated among women;

- women are less likely to have access to appropriate services due to distance, lack of funds, or stigma and discrimination by health workers;

- the clinical course of HIV/AIDS differs in men and women, with different patterns of opportunistic infections. Women are vulnerable to cervical cancer and chronic candidiasis and must deal with issues relating to decisions regarding contraception, pregnancy and breastfeeding;

- women lack knowledge of, and access to, female-controlled HIV/AIDS prevention methods;

- physiological and biological differences between men and women make women more vulnerable to infection than men;

- many women lack knowledge of their own bodies and have little access to information on sexual health. In addition, a significant proportion of women are not aware of their personal risk.

10.6. Component 6: Management Support to NACS

Component Objective: to strengthen the capacity of the National AIDS Council Secretariat (NACS) to co-ordinate multi-sectoral planning and implementation of the MTP and to monitor and review progress towards its achievement.

It is essential that NACS, as the key agency, has an understanding of gender issues and the capacity to ensure that the PNG HIV/AIDS program is gender-sensitive and facilitates the participation of women.

The project can provide training and support the development of operational procedures, policies and guidelines to enhance gender equity and support an active involvement of women at all levels of the program.

Key issues considered in developing gender strategies for this component include the following:

- all project partners, including NAC, NACS, NAC sub-committees and PACs should have an understanding of gender issues including equal opportunity employment, equal status and payment for men and women, and the gender dimensions of HIV/AIDS;

- HRCs are key provincial program implementers and it is essential that they have training and skills in promotion of women's involvement, gender issues, and gender disparities;

- the project grants scheme should discriminate in favour of programs which enhance women's skills and access to information and services, such as community-level income-generating schemes and literacy programs;

- research applications should be sensitive to gender issues and the potential impact of any research study or findings on women;

- it is important that women's groups are not excluded from the project NGO grants scheme due to lack of literacy skills or lack of access to office equipment and resources to prepare grant applications.

Table 1: Gender Planning Framework for PNG National HIV/AIDS Support Project

Key strategies to incorporate a gender perspective into the activities of the PNG National HIV/AIDS Support Project and increase women's participation in project activities are outlined below.

Gender Planning Framework for PNG National HIV/AIDS Support Project		
Overall Strategies **[component-specific strategies are outlined below]**	**Recommended Activities**	**Indicators for assessing gender sensitivity**
All project advisers and partners have the necessary training to enable them to incorporate gender into the planning and implementation of their programs.	• Gender training program, materials and guidelines for project management, advisers and partners	Training report
Gender-sensitive working environment in country, which ensures that attitudes towards female staff are supportive and equal.	• Training in gender for all project staff; • Process established for reporting and reviewing inappropriate behaviour.	Number of reports made Participation in training
The establishment of processes to ensure that program planning takes into account differences in gender roles, access to resources and decision making that affect women's and men's ability to protect themselves against HIV/AIDS.	• Monitoring and evaluation of gender in project activities • Annual gender audit conducted as part of Annual Monitoring and Evaluation Report	M&E report
Project workshops, training programs and meetings facilitate the active participation	• Project ensures the appropriateness of locations and times to ensure both men and women are able to attend;	Minutes of meetings Participation in

of men and women.	• In community-level activities, childcare services are made available to facilitate women's participation; • Meetings structured to ensure that women are able to talk freely about their opinions, feelings and needs.	meetings
Project involves women and women's organisations in policy development and program planning at all levels.	• Project establishes communication links with key women's groups; • Participation by women in meetings.	Number of women's groups working with the project
Specific strategies for Component 1:Education, Information and Advocacy		
Behaviour change programs and messages are relevant to social and cultural roles, traditions and expectations of men and women.	• Social research informs the development of materials; • Women and men involved in planning and implementation of programs at community level.	Review of grants database
CBOs have skills, materials and networks to address gender, sexual violence and legal rights in their programs.	• Gender and sexuality training incorporated into all IEC and behaviour change training programs at all levels; • IEC materials to include legal rights, and sexual negotiation.	Review of IEC materials
Specific materials and programs to address needs vulnerability of women.	• Specialised training and materials for selected CBOs in promotion of female controlled methods of protection including female condoms.	Review of grants program
Community-based HIV/AIDS awareness program addresses gender issues and sexual power.	• NGOs, CBOs and other program partners trained in gender issues; • Programs targeting male sexual violence and sexual decision making supported.	Training report
Targeted interventions identified and supported to address specific high-risk behaviours among men and women.	Possible programs include: • Programs for male clients of sex workers; • Sectoral programs for selected groups such as prisoners, transport	Number of targeted interventions supported

	workers, members of the disciplined forces.	
CBOs with programs addressing male violence, alcohol usage, literacy and income generation have skills and materials to address HIV/AIDS issues.	• HIV/AIDS behaviour change training and materials for selected CBOs that are focused on addressing male violence, income generation for women, literacy, and alcohol abuse.	Review of grants program
Specific strategies for Component 2: Counselling and Home Care		
Counsellors and carers trained in dealing with the realities of violence, lack of rights and control in sexual relationships.	• Gender and sexuality training incorporated into all counselling and care training programs at all levels; • Counselling training unit on behaviour change, safe sex, positive living for advanced counsellor training.	Training curriculum
Greater participation of men in community and home based care.	• Advocate and facilitate greater male participation in counselling and home care training programs; • Advocate for higher profile and status of community and home carers.	Database
Specific and reliable counselling services available for women testing HIV-positive at antenatal clinics.	• Specialised training for counsellors working in ante natal clinics, on topics including breastfeeding, legal rights, addressing violence, and inclusion of men; • Training of ANC and MCH clinic staff in working with HIV-positive women pre and post natally; • Attitudinal training for ANC staff, including legal rights.	Training database
HIV/AIDS counsellors have skills, materials and networks to address violence and crisis counseling.	• Counselling materials to include strategies to address violent responses by spouses; • Counsellor training to cover the topic of sexual violence; • Referral guidelines developed for victims of sexual violence, including incest.	Review of materials

Specific strategies for Component 3: Policy, Legal and Ethical Issues		
Sectoral Response Advisory Committee understands gender and HIV/AID issues, and has the capacity to incorporate these into sectoral policies and programs.	• Provision of gender training for Sectoral Policy Review Group	Training report
Sectoral mainstreaming of HIV/AIDS addresses gender issues in the development of HIV/AIDS policy and programs.	Workshops, training and materials address gender issues in the context of HIV/AIDS, legal rights and PNG's commitment to UN charters; Sector policies reviewed for gender impact.	Training report
Advocacy to raise awareness of the impact of laws against sex workers and male to-male sex.	Project to advocate for review of MSM and sex work legislation.	Progress reported in quarterly report
Specific strategies for Component 4: Monitoring, Surveillance and Evaluation		
Surveillance addresses contextual social and cultural factors that shape sexual behaviour.	• Behavioural surveillance surveys to include questions relating to women's knowledge and ability to practice safe sex;	BSS report
Surveillance does not lead to blaming of female populations.	• Surveillance to include both men and women.	Surveillance report
Surveillance addresses all gender groups.	• BSS to include populations practicing male-to-male sex.	Surveillance report
Specific strategies for Component 5: Medical Services and Laboratory Strengthening		
Health workers have skills, competence and supplies to provide sexual health IEC information and advice on female controlled prevention methods.	• Health worker training to include gender, gender violence, female-controlled methods of protection against HIV/AIDS; • Procurement of female condoms, micro-biocides.	Training curriculum Procurement report

Equal access by men and women to STI clinical care.	• Increase capacity of all levels of health services to manage STIs; • FP/MCH training to include STIs and risk factors for STIs; • Male and female staff available at all STI clinics; • Integration of gender content into health worker training, including non-judgmental assessment of risk factors.	Training curriculum Clinic staff audit
Health workers have skills and knowledge to support victims of sexual violence.	• Health workers trained in crisis counselling, management protocols and referral.	Training curriculum
Health workers competent in addressing specific healthcare needs of women living with HIV/AIDS.	• Health worker training on HIV/AIDS to include specific information on the clinical course of HIV/AIDS in women including cervical cancer; • MCH and ANC health workers training to include HIV/AIDS in context of family planning, ANC, care of HIV-positive infants and breastfeeding.	Training curriculum
Specific strategies for Component 6: Management Support to National AIDS Council Secretariat		
NAC, NACS, PACs and NAC sub-committee members understand gender issues.	• NAC, NACS, PACs and members of NAC sub-committees invited to participate in gender training sessions; • Project to advocate for equal representation of men and women on NAC, NAC sub-committees, PACs and other planning bodies; • Project to provide advice on Equal Opportunity Employment guidelines.	Number participating in training
HIV Response Coordinators (HRCs) have knowledge and understanding of gender issues.	• Project to include modules and materials on gender, legal rights and addressing violence in HRC training program	Training report
HRCs and Provincial Counselling Coordinators have equal status and salary.	• Project to advocate for equal status and salary for HRCs and PCCs.	Progress reported in quarterly report

Ensure equal access of men and women to project grant system.	• Guidelines for applications include protocols for submission and assessment of grants from women's groups with low functional literacy.	Review guidelines
Ensure process in place for assessing gender sensitivity of grant applications.	• Guidelines developed for assessment of grants; • Training for PACs and PACS to address gender, gender sensitivity and legal rights.	Training report
Grant scheme guidelines to encourage positive discrimination towards programs addressing women's needs.	• Grant scheme guidelines reviewed and revised as necessary to encourage positive discrimination towards programs targeting women's needs such as income generation, access to health services or information, literacy programs.	Review of grant guidelines
Ensure processes in place for assessing gender sensitivity of research applications.	• Include review of gender sensitivity in guidelines for review of grant applications.	Review guidelines

11. Implementation of NHASP Gender Strategy:

The implementation of the project gender strategy should begin as soon as possible with the first activities being the training program for project advisers and management, and support for the development of relevant modules and materials for project training.

Technical support for the training could be provided by a short-term consultant/adviser working with a local agency skilled in gender training. The PNG group HELP Resources has skilled trainers, training packages, and extensive experience in training within both the government and non-government sectors.

12. Conclusion

This report outlines a gender framework for the PNG National HIV/AIDS Support Project. While some of the project components have made considerable effort to incorporate gender strategies into their activities, there is still considerable variation amongst advisers in their understanding of gender and gender issues and it will be important to institute training of project advisers and management as soon as possible.

Annex 1

UNGASS Declaration Articles relating to the rights and protection of women

Annex 1 UNGASS Declaration Articles relating to the rights and protection of women

The UN Special Session on AIDS (June 2001) Declaration of Commitment acknowledges that women are overwhelmingly at risk of HIV/AIDS, and that *"Empowering women is essential for reducing vulnerability".*

Articles relating to the rights and protection of women are as follows:

Article 14: Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS.

Article 37: By 2003, calls on development of multisectoral national strategies for combating HIV/AIDS that address gender and age based dimensions of the epidemic and have full participation of those in vulnerable groups and people most at risk particularly women and young people.

Article 54: By 2005 reduce the proportion of infants infected with HIV by 20% and by 50% by 2010 by ensuring that 80% of pregnant women accessing antenatal care have HIV prevention and counselling services available, including access to antiretroviral treatment.

Article 59: By 2005 – develop and implement national strategies that promote advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to enjoy safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.

Article 60: By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

Article 61: By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering, and trafficking in women and girls.

Annex 2

Checklist for Building Gender Equity into Project Design and Implementation

Annex 2: Checklist for Building Gender Equity into Project Design and Implementation

Project Design and Preparation

Preparation

1 Which population groups are served by the project (women only, men only, men and women, other groups)?

2 What information is already available about each population group and women in particular?

3 Has information on women and men's work in the household and community been collected? Is it adequate for the purposes of the project?

4 Has there been consultation with people whose lives will be affected by the project, and what attention has been given to women in this process?

5 Are women involved at all levels in the planning and implementation of the project?

Objectives and Activities:

1 What are the objectives of the project?

2 Have both women's and men's roles been reflected in the project's objectives?

3 Are women's and men's roles reflected in the project's objectives?

4 How do the objectives address the needs and concerns of women and men?

5 What programs, activities and services does the project have to ensure that gender needs and concerns will be addressed?

6 How will the inclusion of women help achieve the objectives?

7 How will the activities and services include women's participation?

8 In what ways will the activities and services benefit women?

9 How will women have access to the opportunities and services that the project provides (e.g. training, travel, empowerment, written materials, health care, security etc)?

10 Are project resources adequate to provide these services for women?

11 Is the project likely to have adverse effects on women?

12 What social, legal and cultural obstacles could prevent women from participating in the project?

13 What plans have been developed to address these obstacles?

Project Implementation

Project Personnel:

1 Are project personnel familiar with gender issues?

2 Are project personnel willing to seek women's participation in implementing the project?

3 To what extent are the female personnel experienced in delivering services to men?

4 To what extent are the male personnel experienced in delivering services to women?

5 If an approach by male staff is not culturally acceptable, will the project make provision for female staff intervention?

6 Are female personnel available for technical resources and technologies?

Operation and Maintenance:

1 How will the project ensure that women have equitable access to, and control of, material and technical resources and technologies?

2 How will women participate in, and contribute to, the maintenance of equipment? Will training be provided?

3 Through what organisation(s) will the women be involved?

4 How will the project affect women's time?

5 Will their workload increase or decrease as a result of innovation or changes (mechanisation, new agricultural outputs and cropping patterns, withdrawals of labour by other household members, changes in distance to gardens, workplaces, water supply, firewood supply etc)?

6 If their workload is decreased, will this involve loss of income for women?

7 Do the technologies introduced by the project require changes in women's work patterns?

Institutional Framework:

1 Does the executing agency demonstrate gender sensitivity?

2 Does the executing agency have adequate power to obtain resources from its own and other institutions to enhance women's participation in project activities?

3 Can the executing agency support and protect women if the project has a harmful or negative impact?

Monitoring and Evaluation:

1 Is sex-disaggregated data collected?

2 Does the project have an information system to detect and evaluate the effects of the project on women and men separately?